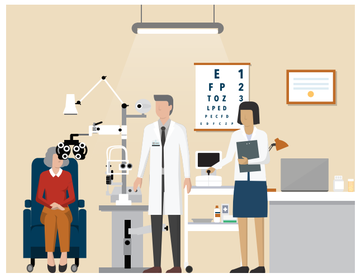
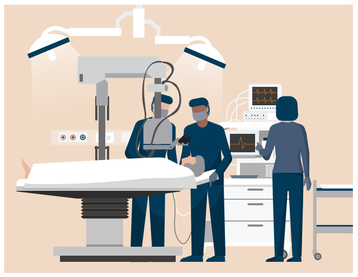
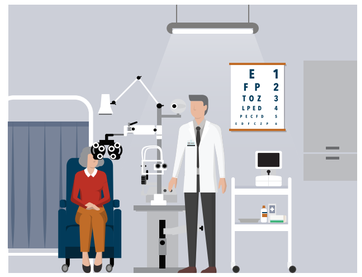
WHAT'S YOUR PLAN TO ENSURE SAFE AND RELIABLE CATARACT SURGERY?

MISTAKES CAN HAPPEN AT ANY POINT →

1		2			3
DOCTOR'S OFFICE		SURGICAL FACILITY			OFFICE
EXAM ROOM	OFFICE	RECEPTION	PRE-OP HOLDING AREA	OPERATING ROOM	EXAM ROOM
					
• Biometry results mis-filed or mis-entered ➘ **WRONG LENS** • Inadequate informed consent on anesthesia and lens choice ➘ **UNANTICIPATED OUTCOMES**	• Lens order unclear or mis-transcribed • Lens order sent last-minute to surgical facility ➘ **WRONG LENS**	• Patient misidentified ➘ **WRONG PATIENT SURGERY**	• Inadequate time-out before eye marking and anesthesia • Delay between time-out and anesthesia ➘ **WRONG EYE ANESTHETIZED** • Insufficient credentialing and orientation of new and contracted anesthesiologists ➘ **IMPROPER EYE BLOCKS**	• Multiple lenses in OR ➘ **WRONG LENS** • Inadequate time-out • Patient misidentified ➘ **WRONG PATIENT SURGERY** • Inconsistent or obstructed site markings ➘ **WRONG EYE SURGERY**	• Discovery of errors and complications

Time-pressured environment | Poor communication | Punitive response to mistakes

EVERYONE PLAYS A ROLE IN PREVENTING HARM →

ARE YOU USING THESE STRATEGIES TO KEEP YOUR PATIENTS SAFE? →

• Engage patient in shared decision-making on anesthesia and lens options	• Use surgical facility's standard lens order form • Avoid handwritten orders • Send lens orders >24 hours before surgery	• Use at least 2 patient identifiers here and at each stage • Use *active* patient confirmation ("What's your name," *not* "Are you Jane Jones?")	• Perform 2+ person time-out right before administering anesthesia • Credential, orient, and observe new anesthesiologists before they perform eye blocks independently	• Perform time-outs to identify patient and to verify eye and lens • Standardize surgical marking • Store lenses outside the OR	• Disclose errors to patient • Notify surgical facility and participate in root cause analysis • Develop and implement corrective action plan to prevent future errors

Standardize internal processes | Adhere to safety protocols | Audit safety practices | Commit to continuous improvement | Foster a culture of safety

BETSY LEHMAN CENTER
for Patient Safety and Medical Error Reduction

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